

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11427

## 11438 CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY KENT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY KENT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN	c. LENGTH OF STAY IN lb 51 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT & QUEEN ANNE'S Hosp	d. STREET ADDRESS Wash. Ave. Ext.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) VIOLA S. BENNETT	First	Middle	Last
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH JAN 9, 1905
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JACOB ALLEN		14. MOTHER'S MAIDEN NAME BELLE BENSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. no	
17. INFORMANT HOSPITAL CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153x DUE TO INTESTINAL OBSTRUCTION INTERVAL BETWEEN ONSET AND DEATH 10 days. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO CARCINOMA OF SIGMOID COLON			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from NOV 22, 1956, to NOV 26, 1956, that I last saw the deceased alive on NOV 26, 1956, and that death occurred at 9 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE C. J. Keefe, Jr. M.D. ADDRESS (Street, city or town, state) DATE SIGNED PHYSICIAN'S NAME (Type) A. T. KEFFE, JR. M.D. CHESTERTOWN, MD 11-26-56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Nov. 29, 1956		22b. DATE THEREOF Nov. 29, 1956	22c. NAME OF CEMETERY OR CREMATOR Y Still Pond Cem.
22d. LOCATION (City, town, or county) Still Pond, Maryland (State)		24a. REC'D BY REGISTRAR Nov. 28-56	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		24b. REGISTRAR'S SIGNATURE Clara L. Barnes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## WISCONSIN STATE DEPARTMENT OF HEALTH—BUREAU OF

## CERTIFICATE OF DEATH

COUNTY

MATERIAL

NAME OF DECEASED

DECEASED PERSON

DATE OF DEATH

BUREAU V. S.

NOV 30 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11493

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11450

Reg. Dist. No. 214

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH o. COUNTY		MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE		MARYLAND b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
56 SILVER SPRING		17 YRS		SILVER SPRING		8415 DIXON AVENUE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		8415 DIXON AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First MELVIN	Middle ALDYNE	Last BILLER	4. DATE OF DEATH	Month NOVEMBER	Day 5	Year 1956
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9/7/99	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Salesman - Shipley Motor Sales				HEPNER, VIRGINIA		U.S.A.		
13. FATHER'S NAME JOHN E. BILLER		14. MOTHER'S MAIDEN NAME ROSE WILLIAMS						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. WV #1		17. INFORMANT MRS. RUTH L. BILLER, 8415 Dixon Ave., Apt. #2		Address Silver Spring, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Coronary occlusion					INTERVAL BETWEEN ONSET AND DEATH sudden	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)								
420.1								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)						
		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED Nov. 5, 1956	
EXAMINER'S NAME (Type) Frank J. Broschart								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 8, 1956	22c. NAME OF CEMETERY OR CREMATORIUM St. Luke's Reformed Church		22d. LOCATION (City, town, or county) Cemetery, Timberville, Va.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warren E. Pumphrey</i>		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE 11/8/56		24b. REGISTRAR'S SIGNATURE <i>Frances Potter</i>		

WEBSITE: [WWW.CERTIFICATEOFDEATH.COM](http://WWW.CERTIFICATEOFDEATH.COM)

BUREAU Y. G.

NOV 13 1956

REGGAE V.EO

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11428

11451

## CERTIFICATE OF DEATH

Reg. Dist. No.

203

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rock Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rock Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Charles	Middle Earl	Last Boulter
4. DATE OF DEATH	Month November	Day 8	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH June 28, 1898	9. AGE (In years last birthday) 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waterman		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
			12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edwin Boulter		14. MOTHER'S MAIDEN NAME Mary Kelly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220-32-0061	17. INFORMANT Lorraine Kendall-Rock Hall, Maryland Address
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Conditions, if any, which gave rise to immediate cause (b), causing (c), stealing the under-lying cause lost.		Carcinoma of left lung INTERVAL BETWEEN ONSET AND DEATH 1 year (t)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 1953, to <u>Nov. 8</u> , 1956, that I last saw the deceased alive on <u>Nov. 3</u> , 1956, and that death occurred at <u>12 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D. ADDRESS (Street, city or town, state) <u>Rock Hall, Md</u> DATE SIGNED <u>11/10/56</u>			
PHYSICIAN'S NAME (Type) WILLARD F. SMITH, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF Nov. 11	22c. NAME OF CEMETERY OR CREMATORIUM Wesley Chapel
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar J. Lane</u>		ADDRESS Church Hill, Md.	24a. REC'D BY REGISTRAR DATE 11/11/56
			24b. REGISTRAR'S SIGNATURE <u>Elwood Brumley</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

BUREAU Y. S.

1956 91 10

RECEIVED  
1956

## INSTRUCTIONS

**TO ATTEND PHYSICIAN OR HOSPITAL.** The law requires that the death certificate be executed within 24 hours after death.

**20 FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

75 A15C 1-55 10M

## **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

11429

Reg. Dist. No. 202

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
<p>COUNTY <b>Kent</b>            CITY (If outside corporate limits, write RURAL            OR and give nearest town)            TOWN <b>Chestertown</b></p> <p>HOSPITAL OR            INSTITUTION OR            STREET ADDRESS  <b>Maple Avenue</b></p>		<p>MARYLAND            LENGTH OF STAY            (In this place)  <b>8 years</b></p> <p>STATE <b>Maryland</b> COUNTY <b>Kent</b>            CITY (If outside corporate limits, write RURAL and give nearest town)            TOWN <b>Chestertown</b></p> <p>STREET            ADDRESS  <b>Maple Avenue</b></p>	
<p>3. NAME OF            DECEASED            (Type or Print)</p> <p><b>Joseph Brice</b></p>		<p>(First) (Middle) (Last)</p>	
<p>5. SEX <b>Male</b></p>		<p>6. COLOR OR            RACE <b>White</b></p>	
<p>7. SINGLE, MARRIED,            WIDOWED, DIVORCED,            (Specify) <b>Single</b></p>		<p>8. DATE OF BIRTH  <b>Nov. 5 1875</b></p>	
<p>9. AGE last birthday  <b>81</b> yrs.</p>		<p>10. KIND OF BUSINESS            OR INDUSTRY  <b>State Road Inspector</b></p>	
<p>11. BIRTHPLACE (State or foreign country)  <b>Kent Co. Md.</b></p>		<p>12. CITIZEN OF WHAT            COUNTRY?  <b>U.S.A.</b></p>	
<p>13. FATHER'S NAME  <b>John Brice</b></p>		<p>14. MOTHER'S MAIDEN NAME  <b>Anne Ford</b></p>	
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES?            (Yes, no, or unk.) <b>No</b>            (If Yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.  <b>218-05-8217</b></p>	
<p>17. INFORMANT &amp; ADDRESS  <b>Miss Harriett Welch, Chestertown</b></p>		<p>18. MEDICAL CERTIFICATION</p>	
<p>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  <b>430.1 IMMEDIATE CAUSE (A) Coronary occlusion</b>            ANTECEDENT CAUSE(S) DUE TO            DISEASES OR CONDITIONS, IF ANY, (B) <b>Coronary insufficiency</b>            GIVING RISE TO THE ABOVE CAUSE            STATING UNDERLYING CAUSE LAST, DUE TO            (C)</p>		<p>INTERVAL BETWEEN            ONSET AND DEATH  <b>5 minutes</b></p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING            TO THE DEATH BUT NOT RELATED TO THE            DISEASE OR CONDITION CAUSING DEATH.</p>		<p><b>2 weeks</b></p>	
<p>19a. DATE OF OPERATION</p>		<p>19b. MAJOR FINDINGS OF OPERATION</p>	
		<p>20. AUTOPSY?            YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>            OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH            (If either, NOTIFY MEDICAL EXAMINER)</p>		<p>21b. PLACE (Home, farm, factory,            OF INJURY street, office bldg., etc.)  <b>at work</b></p>	
<p>21c. WHERE DID INJURY OCCUR? (City or town)  <b>Chestertown</b> (County) <b>Md.</b> (State)</p>			
<p>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)  <b>Nov. 13 1956</b></p>		<p>21e. INJURY OCCURRED            While <input type="checkbox"/> Not while <input type="checkbox"/>            M. at work <input type="checkbox"/> at work <input type="checkbox"/></p>	
		<p>21f. HOW DID INJURY OCCUR?  <b>falling</b></p>	
<p>22. I hereby certify that I attended the deceased from <b>October 21, 1956</b>, to <b>November 8, 1956</b>, that I last saw the deceased            alive on <b>November 7, 1956</b>, and that death occurred at <b>9:00 AM</b>, from the causes and on the date stated above.            SIGNATURE <b>al Dick</b>            ADDRESS <b>Chestertown, Md.</b> DATE SIGNED <b>11-8-56</b></p>			
<p>23. BURIAL, CREMATION,            REMOVAL (SPECIES)  <b>Burial</b></p>		<p>DATE THEREOF  <b>Nov. 10/56</b></p>	
		<p>NAME OF CEMETERY OR CREMATORIAL  <b>St. Paul Cemetery</b></p>	
		<p>LOCATION (City, town, or county)  <b>Fairlee Md.</b> (State)</p>	
<p>24. REC'D BY REGISTRAR  <b>Nov. 13-1956 Clara S. Barnes</b></p>		<p>REGISTRAR'S SIGNATURE  <b>Marvin V. Williams</b></p>	
		<p>25. FUNERAL DIRECTOR'S SIGNATURE  <b>Marvin V. Williams Chestertown, M</b></p>	

DEPARTMENT OF JUSTICE - FEDERAL BUREAU OF INVESTIGATION  
WASHINGON, D. C.

RECEIVED - DEPT. OF STATE

RECORDED IN THE LIBRARY OF THE DEPARTMENT OF STATE

RECORDED NOV 15 1956

FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

NOV 15 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11452 CERTIFICATE OF DEATH

11430

Reg. Dist. No. 2021

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown		c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Strong Nursing Home		d. STREET ADDRESS Kent Circle		e. IS RESIDENCE ON A FARM? / YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) George K. Cannan		First	Middle	Last	4. DATE OF DEATH II/12/56	Month	Day	Year 19
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 27, 1874	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Road Builder		10b. KIND OF BUSINESS OR INDUSTRY owner Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George K. Cannan		14. MOTHER'S MAIDEN NAME Sarah Jane Caulder						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. YES		17. INFORMANT Mrs. Avis Wheatley		Address Chestertown, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized circulatory collapse 4222		7 days						
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis chronic		3 mos.						
(c) Sepsis								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Sept. 26, 1956 to Nov. 12, 1956, that I last saw the deceased alive on Nov. 10, 1956, and that death occurred at f M, from the causes and on the date stated above. ACTUAL SIGNATURE A.C. Dick M.D. DATE SIGNED 11-12-56								
PHYSICIAN'S NAME (Type) A.C. Dick		ADDRESS Chestertown, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 15, 1956		22c. NAME OF CEMETERY OR CREMATORIAL Chester Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR Nov. 14-56		24b. REGISTRAR'S SIGNATURE Clara L. Barnes		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81-290010-A4-H11A3940 TRIMMKA332 STATE GLASS 1110

BUREAU V. S.

NOV 16 1956

REGELY ED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11431

## 11440 CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH o. COUNTY		Kent	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		Maryland	b. COUNTY	Kent
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Chestertown	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rock Hall		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR, INSTITUTION		Kent and Q.A. Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? / YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
John	Randolph	Christian	A	Nov.	12	19	56	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
Male	White		Jan. 22-1903	55 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Maintenance		Food Plant	Virginia		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
Charles Christian		Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT	Address				
O		24-14-227	Mrs. Bessie Christian	--Rock Hall, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Thrombosis					Immediate	
420.1		DUE TO						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)	Hypertensive cardiovascular disease					3 years +
(c)		DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
Hour o. m. p. m.	19	While at work <input type="checkbox"/> of work <input type="checkbox"/>						
21. I certify that I attended the deceased from <u>Feb. 23, 1953</u> , to <u>Oct. 27, 1956</u> , that I last saw the deceased alive on <u>Oct. 27, 1956</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)					DATE SIGNED	
ACTUAL SIGNATURE	<u>Willard F. Smith</u> M.D.					<u>Rock Hall, Md</u>		<u>11/13/56</u>
PHYSICIAN'S NAME (Type)	<u>WILLARD F. SMITH, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county)		(State)			
Nov. 15		Wesley Chapel	Rock Hall, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE				
<u>Eugene J. Lane</u>	Church Hill, Md.	DATE 11/13/56		<u>J. Wood Burgess</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director,  
 please should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE GOVERNMENT OF HAWAII - GARNER 10

HAWAIIAN CERTIFICATE OF DEATH

REAU Y. S.

NOV. 21 1956

REGISTRY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11432

Reg. Dist. No. 202

## 11441 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Kent</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown, R.F.D.</b>		d. STREET ADDRESS <b>/</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Deborah</b>	Middle <b>Elizabeth</b>	Last <b>Davis</b>	4. DATE OF DEATH Month <b>Nov. 28, 1956</b>	Day <b>19</b>	Year	
S. SEX <b>Female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Nov. 23, 1956</b>	9. AGE (In years lost birthday) yrs. <b>5</b>	IF UNDER 1 YEAR Months <b>5</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Chestertown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert L. Davis</b>		14. MOTHER'S MAIDEN NAME <b>Lollie Commodore</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Hospital Records</b>		Address <b>Chestertown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), or (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO <b>776X</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO <b>776X</b>		(c)					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 23, 1956</b> to <b>Nov. 28, 1956</b> , that I last saw the deceased alive on <b>Nov. 28, 1956</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Rock Hall, Md.</b>					
ACTUAL SIGNATURE <b>Willard F. Smith</b>		DATE SIGNED <b>II/29/56</b>					
PHYSICIAN'S NAME (Type) <b>Willard F. Smith Rock Hall, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>II/29/1956</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Sandy Bottom Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>nr. - Chestertown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR <b>Mar. 30-56</b>		24b. REGISTRAR'S SIGNATURE <b>Clara S. Barnes</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

FBI  
BUREAU V. S.

DEC 3 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG207 11-26-56 at

11433  
Reg. Dist. No. 202

## CERTIFICATE OF DEATH

11442

1. PLACE OF DEATH  
o. COUNTY

Kent

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chestertown

c. LENGTH OF STAY IN 1b  
RURAL and give nearest town

2 1/2 hours

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

The Kent &amp; Queen Anne

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)  
o. STATE

Maryland

o. COUNTY

Kent

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Millingtown (Rural)

d. STREET ADDRESS

e. IS RESIDENCE  
ON A FARM?  
YES  NO 3. NAME OF  
DECEASED  
(Type or print)First  
LENAMiddle  
MARIELast  
FUCHS4. DATE  
OF  
DEATH

November 15 1956

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

8. DATE OF BIRTH

1892

May 23 1892

62 yrs.

9. AGE (In years  
less birthday)

Months

10. IF UNDER 1 YEAR

Days

11. IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

August J. Godow

14. MOTHER'S MAIDEN NAME

Shredes

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown)

(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

W.M. Fuchs (son)

Millingtown, Md + hospital  
AddressINTERVAL BETWEEN  
ONSET AND DEATH

3 days

unknown

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

442X

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause lost. 260X

(b)

Cardiovascular renal disease  
with congestive failure -

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AUTOPSY

PERFORMED? YES  NO 

Diabetes mellitus (Possible Kummelstiel-Wilson syndrome)

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a. m. 19  
p. m.20d. INJURY OCCURRED  
White Not while  
of work  of work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 11-15 1956 to 11-15 1956, that I last saw the deceased alive on 11-15 1956, and that death occurred at 8 PM, from the causes and on the date stated above.

ACTUAL  
SIGNATUREPHYSICIAN'S  
NAME (Type)

Robert W. Farr

M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED

Chestertown, Md - 11/15/56

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

burial Nov 21 1956

22b. DATE THEREOF

Crumpton Cemetery

22c. NAME OF CEMETERY OR CREMATORI

Crumpton

22d. LOCATION (City, town, or county)

Md

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Edward Galloway Millington Md

ADDRESS

24a. REC'D BY REGISTRAR

DATE 11-21-56

24b. REGISTRAR'S SIGNATURE

Clara Barnes

W

RECEIVED - STATE DEPARTMENT OF HEALTH - CALIFORNIA

CERTIFICATE OF DEATH

REAU V. S.

APR 21 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11453 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11434

Reg. Dist. No 202

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? / YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Thomas	Middle Homley	Last Month November Day 8 Year 1956
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1890
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Kent County, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Homley		14. MOTHER'S MAIDEN NAME Harriett Broadway	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WW I		16. SOCIAL SECURITY NO. 214-16-4054 17. INFORMANT Address Ida Homley R.F.D. 3, Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable coronary Thrombosis or 420.1 DUE TO Cardiac Arrest INTERVAL BETWEEN ONSET AND DEATH None Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Fell over dead while picking chickens	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Robert W. Farr</i>	DATE SIGNED Nov. 9, 1956		
EXAMINER'S NAME (Type) Robert W. Farr, M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/10/56	22c. NAME OF CEMETERY OR CREMATORIUM Pomona Cem.	22d. LOCATION (City, town, or county) (State) near - Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>		ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR Nov. 10-56 24b. REGISTRAR'S SIGNATURE <i>Clara L. Barnes</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1b. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

EXAMINER'S STATEMENT OF FACTS  
EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

NOV. 13 1956

RECEIVED

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

A34

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11454 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										11435	Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY KENT MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD. b. COUNTY KENT						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WORTON (Rural)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural — WORTON						
d. LENGTH OF STAY IN 1b					d. STREET ADDRESS						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First Rosie	Middle	Last HYNSON	4. DATE OF DEATH	Month Nov	Day 9	Year 1956			
5. SEX Female		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (In years from birthday) 75 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —		17. INFORMANT		Rosie Jones 615 McDonough St. Brooklyn, N.Y. Address			INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 795.3 DUE TO Unknown, but probably from natural causes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Found dead in her home where she lived alone - Last seen alive 11-7-56.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 11/9/56			
EXAMINER'S NAME (Type) ROBERT W. FARR		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-13-56		22c. NAME OF CEMETERY OR CREMATORIAL St. Georges Cemetery		22d. LOCATION (City, town, or county) Worton, Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy Hill Pond, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 11/11/56		24b. REGISTRAR'S SIGNATURE C. Leonard Jones					

STATE OF NEW YORK - ALBANY  
CERTIFICATE OF DEATH

BUREAU V. S.

NOV 14 1956

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film C207 11-20-56 et

## CERTIFICATE OF DEATH

11436  
Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY		. 11443 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland		
Kent				b. COUNTY		Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Chestertown		
Chestertown				d. STREET ADDRESS		Kent St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Kent St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
David				Johnson	Nov. 12, 1956			19
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		B. DATE OF BIRTH	1897	9. AGE (In years Jos. birthday) 59 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
male	colored	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	Sept.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Laborer		Various		Maryland		USA		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				
Horace Johnson				Lousia Blake				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
(If yes, give war or dates of service)		220-01-7019		Bernice Johnson		Cannon Chestertown, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						INTERVAL BETWEEN ONSET AND DEATH Many years		
Arterial Hypertension								
442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)						Hypertensive Cardiovascular Renal Disease Many years		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
Nov. 12, 1956								
21. I certify that I attended the deceased from Nov. 12, 1956, to Nov. 12, 1956, that I last saw the deceased alive on Nov. 12, 1956, and that death occurred at 6:00 P.M. before from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Robert W. Farr M.D. 11/13/56								
PHYSICIAN'S NAME (Type)		Robert W. Farr Chestertown, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)		
Burial		II/15/56		James Cemetery		Chestertown, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
G. Willis Wells		Chestertown, Md.		Nov. 14-56		Clara S. Barnes		

01 JUN 1988 FEDERAL BUREAU OF INVESTIGATION, U.S. DEPARTMENT OF JUSTICE

NOV 16 1956

REGELY ED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11444 CERTIFICATE OF DEATH

Reg. Dist. 11437 02

1. PLACE OF DEATH a. COUNTY <b>Kent</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>Adult Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		d. STREET ADDRESS <b>Wash. Ave. Ext.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>72 Kent &amp; Queen Anne Hosp.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>William J. Miller</b>		First	Middle	Last	4. DATE OF DEATH <b>Nov. 11, 1956</b>	Month	Day	Year	
S. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 8, 1890</b>	9. AGE (In years lost birthday) <b>66 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Automobile Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Augustine Miller</b>		14. MOTHER'S MAIDEN NAME <b>Maude L. Wooley</b>		Address <b>Chestertown, Md.</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Wm. J. Miller</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Bronchogenic Carcinoma (c)						2 years			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>May 24, 1956, to Nov. 11, 1956</b>		20f. (City or town) <b>Chestertown</b>		(County) <b>M.D.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from alive on <b>Nov. 11, 1956</b> , and that death occurred at <b>Chestertown, Md.</b>						that I last saw the deceased alive on <b>Nov. 11, 1956</b> , and that death occurred at <b>Chestertown, Md.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b>			
ACTUAL SIGNATURE <b>Robert W. Farr</b>						DATE SIGNED <b>11/12/56</b>			
PHYSICIAN'S NAME (Type) <b>Robert W. Farr</b>		Chestertown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>II/14/56</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Chester Cemetery</b>		22d. LOCATION (City, town, or county) <b>Chestertown, Md.</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR <b>Nov. 14-56</b>		24b. REGISTRAR'S SIGNATURE <b>Clara J. Barnes</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

RECEIVED  
NOV 16 1956  
FBI - SACRAMENTO  
BUREAU OF INVESTIGATION

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11445 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11438  
Reg. Dist. No. 2021

1. PLACE OF DEATH a. COUNTY <b>Kent</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Kent</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>37 Chestertown</b>		c. LENGTH OF STAY IN 1b <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		d. STREET ADDRESS <b>Calvert St.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>10 Calvert St.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>George</b>		First	Middle	Last	4. DATE OF DEATH <b>Nov. 24, 1956</b>	Month	Day	Year
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 2, 1908</b>	9. AGE (In years last birthday) <b>48 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>various</b>		11. BIRTHPLACE (State or foreign country) <b>Kent. Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>George Murray</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Murray</b>				Address <b>Chestertown, Md.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-05-6700</b>		17. INFORMANT <b>Margaret Murray</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Burns and probable carbon monoxide</b> IMMEDIATE CAUSE (a) <b>916.0</b> DUE TO <b>poisoning</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		
						INTERVAL BETWEEN ONSET AND DEATH		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased was found dead in a burning building in which he had been living.</b>		20c. TIME OF INJURY Month, Day, Year <b>11:00 a.m. NOV. 1956</b>		
		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Chestertown</b> (County) <b>Kent</b> (State) <b>Md.</b>		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural cause <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		ACTUAL SIGNATURE <i>Robert W. Marr</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>Nov. 26, 1956</b>		
EXAMINER'S NAME (Type) <b>Robert W. Marr</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>urn</b>		22b. DATE THEREOF <b>Nov. 28, 1956</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Janes Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Willis Wells</i>		ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR <b>Nov. 27-56</b>		24b. REGISTRAR'S SIGNATURE <b>Clara S. Barnes</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V.

NOV 29 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11446 CERTIFICATE OF DEATH

11439

Reg. Dist. No. 202

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
1SM 9/55

1. PLACE OF DEATH a. COUNTY <b>Kent</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>4 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent &amp; Queen Anne Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Chandley</b>	Middle <b>Fletcher</b>	Last <b>Roberts</b>
4. DATE OF DEATH <b>Nov. 8, 1956</b>	Month Day Year 19		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9/25/1909</b>
9. AGE (In years lost birthday) <b>47</b>	yrs. <b>47</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Kent Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Fletcher Roberts</b>		14. MOTHER'S MAIDEN NAME <b>Eulah Wilson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>184-07-5268</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident -</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio Vascular Disease</b> Years DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 12, 1956</b> , to <b>Nov 8, 1956</b> , that I last saw the deceased alive on <b>Nov 8, 1956</b> , and that death occurred at <b>10 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown</b>			
DATE SIGNED <b>11/8/56</b>			
ACTUAL SIGNATURE <b>Thomas J. Solon</b> PHYSICIAN'S NAME (Type) <b>Thomas J. Solon Chestertown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>II/II/56</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Coleman's Cem.</b>		22d. LOCATION (City, town, or county) <b>Coleman's Corner, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>		24a. REC'D BY REGISTRAR <b>100-10-56</b>	
ADDRESS <b>Chestertown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Clara S. Barnes</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11447 CERTIFICATE OF DEATH

Reg. Dist. No. 11447-202

1. PLACE OF DEATH a. COUNTY <b>KENT</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>QUEEN ANNE'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTERTOWN</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MILLINGTON</b>		d. STREET ADDRESS <b>1783</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENT + QUEEN ANNE'S HOSP</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>MATTIE</b>	Middle <b>ISABELLE</b>	Last <b>ROCHESTER</b>	4. DATE OF DEATH <b>NOV 9 1956</b>	Month <b>NOV</b>	Day <b>9</b>	Year <b>1956</b>

5. SEX <b>F</b>	6. COLOR OR RACE <b>COL</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 22, 1919</b>	9. AGE (In years last birthday) <b>37 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. IF UNDER 24 HRS. Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13. FATHER'S NAME <b>William H. Elliott</b>	14. MOTHER'S MAIDEN NAME <b>Mary V. Lee</b>	Address <b>Hosp. Chapt.</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>213-22-8033</b>	17. INFORMANT <b>Hosp. Chapt.</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Post-OPERATIVE RESPIRATORY DEPRESSION</b> DUE TO <b>584 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>ANESTHESIA FOR CHOLECYSTECTOMY</b> DUE TO (c) <b>CHRONIC CHOLECYSTITIS &amp; CHOLELITHIASIS</b>	INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Chestertown, Md.</b>	(County) <b>11-9-56</b>	(State)

21. I certify that I attended the deceased from <b>NOV 8</b> , 1956, to <b>NOV 9</b> , 1956, that I last saw the deceased alive on <b>NOV 9</b> , 1956, and that death occurred at <b>P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b>					
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ACTUAL SIGNATURE <b>A. T. Keeffe, Jr., M.D.</b>	DATE SIGNED <b>11-9-56</b>
PHYSICIAN'S NAME (Type) <b>A. T. Keeffe, Jr., M.D.</b>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 13, 1956</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Rich Neck Cem.</b>	22d. LOCATION (City, town, or county) <b>Nr. Church Hill</b>	(State) <b>Maryland</b>
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23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Willis Wells</b>	ADDRESS <b>Chestertown, Md.</b>	24a. REC'D BY REGISTRAR <b>Nov. 13-56</b>	24b. REGISTRAR'S SIGNATURE <b>Clara L. Barnes,</b>
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DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

BUREAU Y. E.

OCT 15 1956

DECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11448 CERTIFICATE OF DEATH

Reg. No. 11448-021

1. PLACE OF DEATH a. COUNTY <b>KENT</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Church Hill</b> 178-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent + Queen Anne Hosp.</b>		d. STREET ADDRESS " "		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY</b>		First	Middle	Lost	4. DATE OF DEATH <b>NOVEMBER 3 1956</b>
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 2, 1956</b>	9. AGE (In years lost birthday) <b>0 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>CHARLES FRANKLIN Ross</b>		14. MOTHER'S MAIDEN NAME <b>ALICE ELIZABETH COLEMAN</b>		Address <b>HOSPITAL RECORDS (Mother)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>759.3</b> DUE TO <b>Congenital</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Abnormality of Upper respiratory tract</b> (c) <b>Cleft palate;</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 hr</b>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Congenital heart lesion; spina bifida occulta</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 2, 1956</b> , to <b>Nov. 3, 1956</b> , that I last saw the deceased alive on <b>Nov. 3, 1956</b> , and that death occurred at <b>11:50 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Florence Deringer Joyce M.D.</b>				ADDRESS (Street, city or town, state) <b>Worton, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Florence Deringer Joyce</b>				DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 4, 1956</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Chestertown Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Chestertown, Maryland</b>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Marvin V. Williams - Chestertown Md.</b>		ADDRESS <b>2072386 XV4</b>		24a. REC'D BY REGISTRAR <b>Nov. 6-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Classie Barnes</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH-ENVIRONMENTAL

CERTIFICATE OF DEATH

NAME

ADDRESS

PHONE

AGE

SEX

CAUSE

TIME

PLACE

DEATH

TIME

PLACE

BUREAU V.

NOV 7 1956

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11442

## 11449 CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <b>KENT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTERTOWN</b>		c. LENGTH OF STAY IN 1b <b>35 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kent + Queen Anne's</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JEWELL</b>		First <b>KELLOGG</b>	Middle <b>SMITH</b>
4. DATE OF DEATH Month <b>Nov</b>	Day <b>11</b>	Year <b>1952</b>	5. SEX <b>M</b>
6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 5, 1890</b>	9. AGE (In years last birthday) yrs. <b>66</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>owner</b>	11. BIRTHPLACE (State or Foreign country) <b>NEW YORK</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13. FATHER'S NAME <b>JOHN JEWELL SMITH</b>	14. MOTHER'S MAIDEN NAME <b>MARY PEASLEE</b>	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>UNK</b>	16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT <b>HOSPITAL RECORD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Occlusion</b> DUE TO <b>570.5</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Cerebral Concussion.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>3 min.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebral Concussion.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell down stairs.</b>		
20c. TIME OF INJURY Month, Day, Year Hour <b>Nov 8 1952 9 p.m.</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) <b>Chestertown, Kent Md</b>
(County) <b>(State)</b>			
21. I certify that I attended the deceased from <b>Nov 8, 1952</b> , to <b>Nov 11, 1952</b> , that I last saw the deceased alive on <b>Nov 11, 1952</b> , and that death occurred at <b>5 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A.T. Keeffe, Jr., M.D.</b>		ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>A.T. Keeffe, Jr., M.D.</b>		DATE SIGNED <b>11-11-52</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 14, 1956</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>St. Paul Cem.</b>	22d. LOCATION (City, town, or county) <b>Nr. Chestertown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Willis Wells</b>		24a. REC'D BY REGISTRAR <b>Nov. 14, 1956</b>	24b. REGISTRAR'S SIGNATURE <b>Clara Barnes</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LICEN<sup>S</sup>CENCE OF DEATH

BUREAU V. S.

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11455 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										11443	
Item 14 Film G07 12-3-56 et										Reg. Dist. No. 200	
1. PLACE OF DEATH a. COUNTY <i>Kent</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		o. STATE <i>Maryland</i>		b. COUNTY <i>Kent</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Galts</i>		c. LENGTH OF STAY IN 1b <i>2 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Galts -</i>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)											
3. NAME OF DECEASED (Type or print) <i>Dorothy</i>		First <i>Dorothy</i>	Middle <i>Clara</i>	Last <i>Sommers</i>	4. DATE OF DEATH	Month <i>Nov</i>	Day <i>18</i>	Year <i>1956</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug 14, 1913</i>		9. AGE (In years last birthday) <i>43</i> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>			
13. FATHER'S NAME <i>George Quillen</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Wilbert Sommers</i>		Address <i>Galts, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Brain tumor (postoperative)</i> DUE TO <i>3 months</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Operated in Delaware Jail Hosp., Wilmington Md. in Aug 1956 for above. Hospitalized 8 weeks. Home about (c) <i>last 5 weeks - Found dead in bed about 6 am today</i></i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Millington</i>		(County) <i>Md.</i>		(State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Robert W. Farr</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>								DATE SIGNED <i>Nov 18, 1956</i>	
EXAMINER'S NAME (Type) <i>ROBERT W. FARR</i>		22b. DATE THEREOF <i>Nov 20 1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Millington Cemetery</i>		22d. LOCATION (City, town, or county) <i>Millington</i>		(State) <i>Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Tolson</i>		ADDRESS <i>Millington Md.</i>		24e. REC'D BY REGISTRAR <i>DATE 26 1956</i>		24f. REGISTRAR'S SIGNATURE <i>By Mulford</i>					

DEPARTMENT OF STATE OF CALIFORNIA  
MEDICAL EXAMINER'S OFFICE

BUREAU V.A.  
RECEIVED

NOV 26 1956

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11444

Reg. Dist. No. 202

## CERTIFICATE OF DEATH

11450

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md - b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown		c. LENGTH OF STAY IN 1b 1½ days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Green Annex		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall - rural	
3. NAME OF DECEASED (Type or print) First CLIFTON E Middle		4. DATE OF DEATH Last WESLEY 11 Month / Day 1 Year 1956	
S. SEX Male	6. COLOR OR RACE Color	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov 25, 1913
8. AGE (In years lost birthday) 42 yrs.		9. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oyster shucker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Wesley		14. MOTHER'S MAIDEN NAME Carrie Brokers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Emma Wesley - Rock Hall + to Toledo Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic meningitis 340.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
INTERVAL BETWEEN ONSET AND DEATH 7 days			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/31, 1956, to 11/1, 1956, that I last saw the deceased alive on 11/1/56, 1956, and that death occurred at 10:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Robert W. Farr M.D. PHYSICIAN'S NAME (Type) ROBERT W. FARR			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/5/56	
22c. NAME OF CEMETERY OR CREMATORIUM Sharptown Cem.		22d. LOCATION (City, town, or county) Rock Hall, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR Nov. 5-56		24b. REGISTRAR'S SIGNATURE Clara S. Barnes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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